STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

August 6, 2018

Patrick L. Green, President/CEO
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Dear Mr. Green:

Unannounced visits were made to Lawrence & Memorial Hospital on May 30 and July 19, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by August 20, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

We do not anticipate making any practitioner referrals at this time.

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DATES OF VISIT: May 30 and July 19, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:lst

CT #'s 23136, 23570

DATES OF VISIT: May 30 and July 19, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3), and/or (e) Nursing Service (1) and/or (i) General (6).

1. Based on a review of clinical records, interview and policy review, for one of three patients reviewed for care and services, (Patient #1), the facility failed to ensure the patient had nothing by mouth prior to having a colonoscopy resulting in aspiration pneumonia. The finding includes the following:
   a. Patient #1 presented to the facility on 11/9/17 for an outpatient colonoscopy. Review of the clinical record identified that the patient had a history laparoscopic right colectomy on 8/14/13, for colon polyps, gastroesophageal reflux disease (GERD), developmental disability, asthma, and obsessive compulsive disorder.

      Review of the patient's nothing by mouth status (NPO) status noted that the last liquid consumed was on 11/8/17 at 10 PM and last solid food consumption was on 11/7/17 at 9:35 AM. Review of the Anesthesiologist's pre-operative note dated 11/9/17 at 10:07 AM identified that the patient's nothing by mouth status (NPO) was reviewed, the patient's breath sounds were clear to auscultation with an anesthesia plan for monitored anesthesia care (MAC).

      Review of the record noted that anesthesia started at 11:49 AM, the procedure started at 11:51 AM, and during the procedure the patient aspirated and vomited dark brown liquid. Review of the colonoscopy note by MD #1 indicated the scope was up to the splenic flexure when the patient began to vomit large amounts of dark material. Shortly after vomiting the patient's oxygen saturation went down, the scope was immediately removed and anesthesia took over management of the hypoxemia and probable aspiration. There was a brief period of time when there was no obvious pulse and chest compressions were performed. Shortly after intubation, the patient had a good pulse and oxygen saturations, was transferred to the emergency room and admitted to the intensive care unit.

      Review of the discharge summary dated 11/28/17 identified that during the initiation of the procedure (colonoscopy) an episode of aspiration with significant pneumonia, acute respiratory distress, mechanical ventilation with a prolonged ICU stay, maintained on a ventilator. The patient remained frail and unstable, developed acute renal failure with hemodialysis recommended. The patient's guardian decided against hemodialysis and the patient was terminally extubated and expired on 11/28/17.

      Interview with RN #1 on 7/19/18 at 11:20 AM stated that on 11/9/17 the patient was brought to the procedure room and while in the procedure room waiting for the physician the patient repeatedly kept asking for something to drink. RN #1 stated that at some point CRNA #1 left the room and returned with a cup of coffee and gave it to the patient who drank approximately 4 ounces of fluid. RN #1 stated that he questioned the CRNA and she

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indicated that it was not a problem. RN #1 stated that shortly after the procedure was started the patient started to retch and subsequently vomited, a large amount of brown coffee ground like fluid. RN #1 stated that 200 cubic centimeters (cc) was suctioned from the patient. The record lacked documentation to reflect that the patient was provided fluids prior to the procedure, including the amount and/or type of fluids.

Interview with MD #4 (Anesthesiologist) on 7/19/18 at 12:30 PM stated it is not the standard of care to give a patient fluids prior to the procedure. Interview with MD #1 on 7/19/18 at 1:15 PM stated if he was aware that the patient had oral fluids prior to the procedure on 11/9/17, he would have cancelled the procedure. The Certified Registered Nurse Anesthetist (CRNA) that provided the fluids to the patient on 11/9/17 was no longer employed by the hospital, therefore, an interview was not conducted.

Review of the Anesthesia Practice Guidelines indicated that minimum fasting period for patients undergoing an elective procedure is two hours.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6) and/or (l) infection control (1).

2. Based on observation, interview, and policy review the facility failed to ensure that the patient positioning gel pads used during operative procedures were without open areas which comprised the surface integrity. The findings include the following:
   a. During tour of the operating room (O.R) department it was identified that OR #7 was recently used, cleaned and in preparation for another case. Two arm positioning gel pads were identified to have open areas on the top and bottom surfaces rendering the pads to be exposed to contaminate and ineffective cleaning. Upon surveyor enquiry it was identified that the gel pads were recently used and cleaned. The O.R. manager identified that the gel pads should not be used if there are torn areas evident, that all staff are responsible for checking the gel pads and that the pads are sent to biomed for repair if damaged. The two pads were removed following surveyor inquiry.